# DEPARTMENT OF MANAGED HEALTH CARE
# CALIFORNIA HMO HELP CENTER
# DIVISION OF PLAN SURVEYS

# ROUTINE MEDICAL SURVEY

# OF

# MEDICAL PLAN

# FINAL REPORT

# WATTS HEALTH FOUNDATION, INC.

## ISSUED TO PLAN: DECEMBER 11, 2003

## ISSUED TO PUBLIC: DECEMBER 21, 2003

Watts Health Foundation, Inc.

**Final Report of Routine Medical Survey of a Full Service Plan**

**December 11, 2003**

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# EXECUTIVE SUMMARY

The California Department of Managed Health Care (the "Department") conducts a medical survey of each licensed health care service plan at least once every three years to evaluate the plan's compliance with the Knox-Keene Act in the areas of grievances and appeals, utilization management, access and availability, and quality management. The survey includes an on-site visit, a review of documents, and interviews with the plan's staff and its providers.

In June 2003, the Department surveyed the medical component of Watts Health Foundation, Inc. (the "Plan"). This not-for-profit medical plan serves approximately 107,000 enrollees through its Medi-Cal, Medicare, Commercial, Healthy Families and AIM products. Most services operate through its network of 1,800 primary care physicians and 5,500 specialists. The Plan does not delegate its grievance and appeals functions to other entities. The Plan delegates Utilization Management (UM) functions such as preauthorization review, concurrent review, and retrospective review to any of its Preferred Provider Networks (PPN) that pass the Plan's pre-delegation audit; the Plan performs its own UM functions for non-delegated PPNs and for services for which the Plan is at risk. In the area of quality management, only primary source verification for credentialing is delegated.

The Department found four (4) deficiencies in the area of **Grievances and Appeals**. Two of these deficiencies are now fully corrected. The Plan has implemented corrective actions for the remaining deficiencies, which are listed below. These deficiencies will be re-evaluated during the Follow-up Review:

- The Plan does not consistently:
  - A) Acknowledge the receipt of a grievance within five calendar days;
  - B) Provide the enrollee with a written resolution of the grievance within 30 calendar days of receipt of the grievance; and
  - C) Display the Department's telephone number, the California Relay Service's telephone number, and the Department's Internet address in 12-point boldface type in its acknowledgment and response letters to grievances.

    (Note: Issue C is now corrected; Issues A and B will be re-evaluated at the time of the Follow-up Review)

- The Plan does not consistently specify the provision in the contract, evidence of coverage or member handbook that excludes the service in its benefit denial letters.

The Department found one (1) deficiency in the area of **Access and Availability of Services**. The Plan has initiated corrective actions for this deficiency, which is listed below. The deficiency will be re-evaluated during the Follow-up Review:

- The Plan does not have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which include, but are not limited to, waiting time and appointments. (*This deficiency is a Repeat Deficiency. The deficiency was noted at the last routine medical survey and remained uncorrected at the time of the Follow-up Review.*)

The Department found five (5) deficiencies in the area of **Utilization Management**. One (1) of these deficiencies is now corrected. The Plan has initiated corrective actions for the remaining four (4) deficiencies, which will be re-evaluated during the Follow-up Review:

- The Plan does not ensure adequate telephone access for providers to request authorization for health care services.

- The Plan does not consistently notify the enrollees in writing or otherwise, when a request for authorization of health care services is delayed or pended when the Plan is not in receipt of all the information reasonably necessary to make a decision. The Plan does not notify the enrollees and providers of the anticipated date on which a decision is likely to be rendered when it becomes aware of the expiration of the timeframe required to process the request for authorization.

- The Plan does not consistently provide a clear and concise explanation of the reasons for treatment denial decisions.

- The Plan does not provide adequate oversight of delegated PPNs to ensure compliance with Plan standards and all applicable statutes and regulations.

The Department found two (2) deficiencies in the area of **Quality Management**. The Plan has initiated corrective actions for both of these deficiencies. The deficiencies will be re-evaluated during the Follow-up Review:

- The Plan does not investigate potential quality issues (PQIs) in a timely manner in order to ensure that the care provided to all enrollees meets professionally recognized standards of practice. (*This deficiency is a Repeat Deficiency. The deficiency was noted at the last routine medical survey and remained uncorrected at the time of the Follow-up Review.*)

- The Plan does not consistently evaluate patterns and trends in quality of care issues and does not monitor provider specific and Plan-wide quality performance issues.

# I. INTRODUCTION

The Knox-Keene Health Care Service Plan Act of 1975 (the "Act"), Section 1380, requires the Department to conduct a survey of each licensed health care service plan at least once every three years. The survey is a comprehensive evaluation of a plan's compliance with the Knox-Keene Act. The subjects covered in the survey are listed in Health and Safety Code Section 1380 and in Title 28 of the California Code of Regulations, Section 1300.80.[1] A copy of this report will be sent to the Office of Enforcement.

Generally, the survey reviews the major areas of grievances and appeals, utilization management, access and availability, and quality management in the following specific categories:

- Procedures for obtaining health care services;
- Procedures for reviewing and regulating utilization of services and facilities;
- Procedures for reviewing and controlling costs;
- Peer-review mechanisms;
- Design, implementation and effectiveness of the internal quality-of-care review systems;
- Overall performance of the plan in providing health care benefits; and
- Overall performance of the plan in meeting the health needs of enrollees.

The Department regards a plan's Grievance and Appeals process as a core mechanism that enrollees can utilize to exercise their rights if they need to resolve problems with their HMO. The Department requires plans to resolve all grievances and appeals in a professional and expeditious manner. This requirement is pursuant to the Knox-Keene Health Care Service Plan Act of 1975, beginning at Section 1368, and the corresponding regulations promulgated pursuant to the Act under Title 28 of the California Code of Regulations, beginning at Rule 1300.68.

The Department's continued efforts to ensure that enrollees have the ability to exercise their rights reflect additions to the Grievance and Appeals regulations enacted as of February 2003. The Department vigorously enforces these regulations to ensure that enrollees are able to obtain the services to which they are legally entitled.

This Final Report summarizes the findings of the routine medical survey of the Plan. The Plan submitted pre-survey documentary information to the Department on May 20, 2003. The on-site review of the Plan was then conducted between June 9, 2003 and June 12, 2003. The exit conference was held on June 12, 2003.

As part of the survey process, the survey team conducted interviews and examined documents at the Plan's administrative offices in Inglewood, CA. The names of the survey team members are listed in Appendix A. A list of Plan officers and staff that were interviewed is found in Appendix B. A list of staff interviewed at the medical groups is found in Appendix C. Appendix D contains the list of applicable statutes and regulations and specific citations used in

[1] References throughout this report to "Section ____" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as amended [California Health and Safety Code Section 1340 *et seq*. ("the Act") References to "Rule ____" are to the regulations promulgated pursuant to the Act [Title 28 of the California Code of Regulations, beginning at Section 1300.43 ("the Rules")].

this Final Report as the basis for the deficiencies. Appendix E is a list of acronyms used in this Final Report.

The Preliminary Report of the survey findings was sent to the Plan on September 22, 2003. All deficiencies cited in the Preliminary Report required follow-up actions by the Plan. In turn, the Plan was required to submit a response to the Preliminary Report within 45 days of receiving it. The Plan complied by submitting its response on November 7, 2003.

In addition to requiring follow-up actions, the Department may also take other actions in regards to violations, including enforcement actions.

The Final Report contains the following: the survey findings as reported in the Preliminary Report; a summary of the Plan's Response; and the Department's determination concerning the adequacy of the Plan's response. The Plan must file an amendment to the Department concerning any modifications to the Exhibits of the Plan's licensing application as a result of its Corrective Action Plans (CAPs). If the Plan wishes to append its response to the Final Report, it must notify the Department before December 21, 2003.

Any member of the public who wants to read the Plan's entire response and view the Exhibits attached to it may do so by visiting the Department's office in Sacramento, California, after December 21, 2003. The Department will also prepare a Summary Report of the Final Report that will be available to the public at the same time as the Final Report.

One copy of the Summary Report is also available free of charge to the public by mail. Additional copies of the Summary Report and copies of the entire Final Report and the Plan's response can be obtained from the Department at cost. The Final Report to the public will be placed on the Department's website: www.dmhc.ca.gov.

The Plan may file an addendum to its response anytime after the Final Report issues to the public. Copies of the addendum also are available from the Department at cost. Persons who want copies of any addenda filed by the Plan should specifically request the addenda in addition to the Plan's response.

Pursuant to Health and Safety Code Section 1380(i)(2), the Department will conduct a Follow-up Review of the Plan within 18 months of the date of the Final Report to determine whether the deficiencies identified by the Department have been corrected. Please note that the Plan's failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health & Safety Code Section 1380(i)(1).

Preliminary and Final Reports are "deficiency" reports; that is, the reports focus on deficiencies found during the medical survey. Only specific activities found by the Department to require improvement are in these reports. Omission of other areas of the Plan's performance does not necessarily mean that the Plan is in compliance with the Knox-Keene Act. The Department may not have surveyed these activities or it may not have obtained sufficient information to form a conclusion about the Plan's performance.

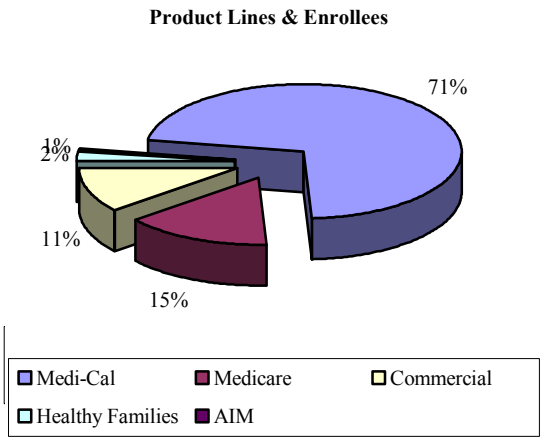
# II. OVERVIEW OF PLAN OPERATIONS AND HEALTH CARE DELIVERY SYSTEM

The following summary is based on information submitted to the Department by the Plan in response to the Pre-Survey Questionnaire and other on-site documents:

| | | | |
|---|---|---|---|
| **Date Plan Licensed** | January 30, 1978 | | |
| **Type of Plan** | Network Model HMO | | |
| **For profit / Non-profit Status** | Not-for-profit | | |
| **Service Area(s)** | | | |
| **Commercial HMO Service Area** *(Counties, in full or in parts)* | Los Angeles | Orange | San Bernardino/ Riverside |
| **Medicare HMO Service Area** *(Counties, in full or in parts)* | Los Angeles | Orange | San Bernardino/ Riverside |
| **Medi-Cal Service Area** *(Counties, in full or in parts)* | Los Angeles | | |
| **Healthy Families** *(Counties, in full or in parts)* | Los Angeles | Orange | San Bernardino/ Riverside |
| **Access for Infants and Mothers (AIM)** *(Counties, in full or in parts)* | Los Angeles | | |
| **Number of Physicians** | **Primary Care Physicians** | **Specialty Care Physicians** | |
| | 1824 | 5460 | |
| **Number of Affiliated Medical Groups - Or IPAs or PPNs** | 53 | | |

**Number of Enrollees as of May 2003**

| Product Lines | Enrollees |
|---|---|
| | |
| **Medi-Cal** | 76,152 |
| | |
| **Medicare** | 15,896 |
| | |
| **Commercial** | 11,509 |
| | |
| **Healthy Families** | 2,354 |
| | |
| **AIM** | 620 |
| **Total** | **106,531** |




## A. Organizational Background and Structure

WATTS Health Foundation, Inc. (the Plan), dba UHP Healthcare, is a non-profit, 501(c) corporation. The Foundation was established in 1967, under the name South Central Multipurpose Health Services Center, serving the people in the 3.5 square mile Watts Community by providing direct patient care and health education services. The Foundation established United Health Plan in 1973 as one of its subsidiaries (originally called the Watts Health Plan). United Health Plan underwent a name change to UHP Healthcare in 1997. UHP Healthcare is a full-service Knox-Keene plan licensed by the Department. The Plan provides a comprehensive system of medical services, including adult medicine, obstetrics and gynecology, pediatrics, urology, dermatology and physical therapy, as well as pharmacy, vision and dental care. Its focus is serving "special needs" and vulnerable populations such as low-income individuals, the aging, and the working poor in an ethnically diverse community.

In the fall of 2001, the Department appointed a Conservator to oversee the Knox-Keene license operations of the Plan. This action was directly tied to the Plan's financial loses in 2000, which impacted the minimum reserve limits (Tangible Net Equity) as required by the Department. Another goal of the Conservatorship was to ensure the successful separation of several of the integrated companies of Watts Health Systems that were experiencing financial difficulties. The last of these affiliated organizations (Watts Health Center) was separated from the WATTS Health Foundation in April 2003 and the health Plan, UHP Healthcare, is now a distinct entity. The Conservator also currently performs oversight activities that would typically be the responsibility of a Governing Body or Board of Directors.

## B. Delivery Model

The Plan is a full-service health plan operating in the following service areas: Los Angeles (where approximately 90% of its membership reside); Orange; and San Bernardino. It utilizes a mixed health services delivery model: IPAs/Medical Groups, termed "Preferred Provider Networks" (PPNs), and a direct contracted network.

The Plan is a federally qualified Health Maintenance Organization (HMO). Just over 70% of its patient population is Medi-Cal, through a contract with LA Care Health Plan in Los Angeles County. The Plan is also a Medicare+ Choice Health Plan contractor with the U.S. Center for Medicare and Medicaid Services (CMS), which accounts for another 15% of its membership. The remainder of its membership is enrolled in the Plan's commercial products, including Commercial Employer Groups, Individual/Family Plan, AIM, Healthy Families, and Federal Employees Health Benefits Program (FEHB).

The Plan contracts with hospitals, skilled nursing facilities, home health agencies, freestanding ambulatory surgical centers and other ancillary providers. The Plan delivers all primary care medical services to enrollees through contracted PPNs. The enrollees access primary and specialty care through their selected PPNs.

The Plan contracts with a pharmacy benefit management company, MedImpact, to administer its pharmacy benefit program. The Plan is responsible for any pharmacy denial decisions and formulary changes.

**Arrangements for Obtaining Specialty Care**

Each PPN, through its network of contracted specialists, provides specialty care. Each Primary Care Provider (PCP) Group is responsible for establishing reimbursement methodologies with its contracted specialty providers. The enrollee's PCP must authorize referral to a specialist.

**Arrangements for Obtaining In-patient Care**

The Plan contracts with hospitals to provide inpatient services. The Plan has both full-risk contracts and shared-risk contracts with PPNs for in-patient services. Members must seek authorization for inpatient care from their PCPs through the notification/pre-certification process.

**Arrangements for Obtaining Emergency Services**

The Plan has policies, procedures and processes to ensure that emergency health care services are available and accessible within the service area 24 hours a day, seven days a week. The Plan uses the "prudent lay person" definition to determine coverage for emergency services.

**Risk Assumption for Health Care Services**

All direct primary care medical services are delivered to enrollees through the Plan's contracted PPNs. The PPNs have full-risk (responsibility) contractual arrangements for primary care services and shared-risk arrangement for in-patient services. Shared-risk means that the Plan is responsible for facility-related charges while the PPNs are responsible for professional services.

The following table presents the distributions of risk between the Plan and its providers:

| SERVICES | Plan/PPN Share Risk | Plan Takes Full Risk | PPN Takes Full Risk |
|---|---|---|---|
| PRIMARY CARE | | | X |
| SPECIALTY CARE | X | | |
| IN-PATIENT HOSPITAL (includes in-patient pharmacy, diagnostics and ancillary services) | X | Facility charges | Professional fees |
| OUT-PATIENT PHARMACY | | X | |
| EMERGENCY SERVICES | X | X | X |
| LABORATORY SERVICES | | | X |
| DIAGNOSTIC SERVICES | | | X |
| ALLIED HEALTH SERVICES | | | X |
| NURSING HOME | | X | X |
| HOME HEALTH | | X | X |
| HOSPICE | | X | X |
| OTHER: | | | |
| *Chiropractic* | | X | X |
| *Vision* | | | X |
| *Mental Health (out-patient)* | | | X |
| *Mental Health (in-patient)* | | X | X |

## C. Delegated Functions and Plan Oversight Activities

The Plan does not delegate the functions of its grievance process to other entities.

The Plan delegates Utilization Management (UM) functions to PPNs that passed the Plan's pre-delegation audit. The delegated PPNs perform UM functions including preauthorization review, concurrent review, and retrospective review for health services for which they have assumed risk, while the Plan performs UM functions for services for which it is at risk (e.g., in-patient services) and for non-delegated PPNs.

The Plan's Quality Management (QM) Department is responsible for verifying that UM functions are performed in accordance with its established standards. The Plan has developed a structured oversight process that includes initial, periodic, and interim reviews and reports to evaluate the programs of PPNs that have requested and received delegation for UM activities. A major component of this oversight is the annual Comprehensive Delegate Oversight Audit (CDO) the Plan conducts on each delegated PPN. However, the Plan has not conducted any oversight audit of its PPNs since 2002.

In the area of Quality Management, the Plan delegates no functions to PPNs except primary source verification for credentialing.

## D. Plan Operational Functions

### Grievance and Appeals

All Plan enrollees have the right to file a grievance by calling, writing, or personally meeting with Plan staff. The Plan defines a grievance as an oral or written expression of dissatisfaction, a complaint, or a concern by an enrollee regarding an administrative issue and/or dental care received. A grievance can be filed within 180 calendar days following any incident or action that is the subject of the enrollee's dissatisfaction. A grievance may include issues such as a provider (or its office staff) being rude, delay in claims payment, and quality of care that may involve the appropriateness of care. Plan policy requires that all grievances received be acknowledged in five calendar days, and the grievances be resolved within 30 calendar days. If a grievance received in writing or by telephone is made in a language other than English, the Plan requires that responses to the enrollee be made in the same language. If the enrollee is not satisfied with the outcome of the grievance, he/she has the right to contact the Department. Medi-Cal enrollees may also apply for a State Fair Hearing. An enrollee may also request direct review by the Department, if he/she believes or alleges that his/her enrollment has been canceled or not renewed for reasons unclear to the enrollee.

At the time of the survey, Joseph W. Spooner, MD, MBA, was the Plan's VP and Chief Medical Officer, Darryl Leong, MD, MPH, serves as the Medical Director. Under the direction of the VP of Business Operation, the Director of Member Services has complete oversight responsibility for the grievance and appeals process.

As of May 2003, the Plan has enrolled approximately 106,500 members in its Medi-Cal, Medicare, Commercial, Healthy Families, and AIM (Access for Infants and Mothers) programs. For the four-month period January through April 2003, the Plan received and processed a total of 412 "Quick Grievances," (i.e., grievances exempt under Section 1300.68[d][8]); 48 regular 30-day grievances; and 179 standard appeals. A large majority of these standard appeals, 155 cases or 87%, were for claims and service denials. The Plan has had no recorded cases of expedited grievances, no experimental/investigational appeals, and no IMRs during the 15-month period January 2002 through March 2003.

The following table reflects grievance decisions made by the Plan for the four-month period, January through April 2003:

***Summary of Grievance Decisions***
***January 2003 to April 2003***

| Type of Grievance | # Received | Resolved in Favor of Enrollee |
|---|---|---|
| Quick Grievances | 412 | 313 (76%) |
| 30-day Grievances | 48 | 36 (75%) |
| Standard Appeals | 179 | 166 (93%) |

| Type of Grievance | # Received | Resolved in Favor of Enrollee |
|---|---|---|
| Expedited Appeals | 0 | -- |
| Experimental/Investigational Appeals | 0 | -- |
| Independent Medical Reviews (IMRs) | 0 | -- |

**Utilization Management**

The Plan's Utilization Management Program is part of its Clinical Care Coordination (CCC) Department, which performs preauthorization, concurrent review, and retrospective review of services. In the case of retrospective review, the CCC staff members screen treatment authorization requests or claims for services already provided and authorize them based on the Plan's established criteria. The Plan's medical staff personnel review those requests that do not meet the criteria for determination. The CCC Department provides case management to specific high-risk enrollees through its High Risk Patient Management Program. High-risk enrollees are classified as those with chronic diseases and conditions such as diabetes, hypertension and trauma.

The CCC Department works with the Plan's pharmacy benefit management vendor, MedImpact, to administer the Plan's formulary. The Plan's medical staff members make the final decision on any pharmacy denial.

As noted earlier, the Plan delegates significant portions of UM to the PPNs with which the Plan contracts. Oversight of these delegated UM functions is the responsibility of the Plan's Quality Management (QM) department. The QM department assumed this responsibility from the Clinical Care Department in November 2002.

**Access and Availability**

The Plan has established access and availability standards for PCPs, specialists and hospitals with regard to issues such as appointment availability, geographic distribution of providers, hours of operation, and after-hours services. The following table lists key standards for access and availability. These standards are communicated to enrollees through distribution of Member Handbooks and Combined Evidence of Coverage Information at the Plan level and through Enrollee Education Materials at the provider level. These access and availability standards are communicated to network providers via provider contracts and during on-site reviews or provider audits.

| Type | Standard |
|---|---|
| Emergency Care | Immediately |
| Urgent Care | Within 24 Hours |
| Non-Urgent Care | Within 14 Business Days |
| Specialty Referral | Within 10 Business Days |
| Preventive Care | Within 30 Business Days |
| Waiting Room Time | 45 Minutes or Less |
| After-Hours Care | Monday-Friday 5 PM-9 AM |

| Type | Standard |
|---|---|
| | Saturday & Sunday – All Day |
| Telephone Abandonment Rate | 5 % (Plan Level) |
| Call Wait Times | Must Answer Phone within 30 Seconds<br>Non-Recorded Voice Must Answer |

The Plan provides additional access and availability oversight of its provider network via routine provider audits and by the establishment of written access related policies and procedures. The Board of Directors (BOD) normally provides oversight for the Quality Management Committee (QMC); however, as a result of the appointment of the Conservator the BOD has been temporarily disbanded. Currently the Conservator is acting as the Governing Body (BOD) of the Plan until a formal Board can be established. The QMC and BOD are responsible for ensuring that chronic and/or systemic Quality Management (including access and availability) issues are reported, monitored and evaluated.

**Quality Management**

The Quality Management Committee (QMC) is responsible for overseeing the Quality Management Program and, thereby, ensuring the quality of care delivered to the Plan's enrollees. The duties of the QMC include overseeing credentialing, monitoring data on Plan-wide and provider-specific performance and availability, developing care guidelines and conducting projects for on-going quality improvement. The QMC is accountable to the Board. Due to the appointment of the Conservator, however, the QMC reports directly to the Conservator. A Quality Improvement Subcommittee has been established to select topics for quality improvement projects, oversee implementation and monitor project outcomes. Day-to-day Quality Management operations are under the direction of the Chief Medical Officer with the assistance of the Director of Quality Management and the Quality Management staff.

# III. SUMMARY STATUS OF DEFICIENCIES

The following section contains the status of the deficiencies based on the Department's review of the Plan's response to the Preliminary Report. For the deficiencies that are listed as Uncorrected, the Department found that, although the Plan had initiated corrective actions in response to its deficiencies, the Plan has not had enough time during the 45-day response period to provide sufficient evidence that it has effectively implemented the corrective actions. Unless otherwise noted, those deficiencies that have not been fully corrected within the 45-day response period will be reviewed for full correction at the time of the Follow-up Review. Please refer to Section IV of this Final Report for specific discussion on the status of all deficiencies listed below. Section V represents the current status of those Deficiencies found at the last routine medical survey conducted in June 2000 with the Final Report issued to public file on February 14, 2001, that remained uncorrected at the time of the Follow-up Review. Those uncorrected Deficiencies were addressed in the Follow-up Report, which was issued to the public on September 25, 2002.

At the time of the Follow-up Review, the Department will review and report on the current status of the Plan's correction of the uncorrected deficiencies.

## GRIEVANCES and APPEALS

**Deficiency 1:** **The Plan does not have established criteria that address enrollees who have terminal illnesses and who have been denied coverage for treatment, services or supplies that are deemed experimental or investigational.** [Section 1368.1(a)]

**STATUS: CORRECTED**

**Deficiency 2:** **The Plan does not consistently:**

**A) Acknowledge the receipt of a grievance within five calendar days;**

**B) Provide the enrollee with a written resolution of the grievance within 30 calendar days of receipt of the grievance; and**

**C) Display the Department's telephone number, the California Relay Service's telephone number, and the Department's Internet address in 12-point boldface type in its acknowledgment and response letters to grievances.** [Rules 1300.68(d)(1) and (3) and 1300.68(b)(2)]

**ISSUE A: UNCORRECTED**
**ISSUE B: UNCORRECTED**
**ISSUE C: CORRECTED**

**Deficiency 3:** **The Plan does not consistently provide enrollees with written responses to grievances that include a clear and concise explanation of the reasons for the Plan's determination. The Plan's resolution letters do not adequately address all enrollees' concerns and expressions of dissatisfaction.** [Rule 1300.68(d) (4)] (*Repeat Deficiency)*

**STATUS: CORRECTED**

**Deficiency 4:** **The Plan does not consistently specify the provision in the contract, evidence of coverage or member handbook that excludes the service in its benefit denial letters.** [Rule 1300.68(d)(5)]

**STATUS: UNCORRECTED**

## ACCESS and AVAILABILITY

**Deficiency 5:** **The Plan does not have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which include, but are not limited to, waiting time and appointments.** [Rule 1300.67.2(f)] (*Repeat Deficiency* )

**STATUS: UNCORRECTED**

## UTILIZATION MANAGEMENT

**Deficiency 6:** **The Plan does not show evidence of the Medical Director's responsibility for Utilization Management.** [Section 1367.01(c)]

**STATUS: CORRECTED**

**Deficiency 7:** **The Plan does not ensure adequate telephone access for providers to request authorization for health care services.** [Section 1367.01(i)]

**STATUS: UNCORRECTED**

**Deficiency 8:** **The Plan does not consistently notify the enrollees in writing or otherwise, when a request for authorization of health care services is delayed or pended when the Plan is not in receipt of all the information reasonably necessary to make a decision. The Plan does not notify the enrollees and providers of the anticipated date on which a decision is likely to be rendered when it becomes aware of the expiration of the timeframe required to process the request for authorization.** [Section 1367.01(5)]

**STATUS: UNCORRECTED**

**Deficiency 9:** **The Plan does not consistently provide a clear and concise explanation of the reasons for treatment denial decisions.** [Section 1367.01(h)(4)]

**STATUS: UNCORRECTED**

**Deficiency 10: The Plan does not provide adequate oversight of delegated PPNs to ensure compliance with Plan standards and all applicable statutes and regulations.** [Section 1367.01(a)]

**STATUS: UNCORRECTED**

## QUALITY MANAGEMENT

**Deficiency 11: The Plan does not investigate potential quality issues (PQIs) in a timely manner in order to ensure that the care provided to all enrollees meets professionally recognized standards of practice.** [Rule 1300.70(a)(1) and (3) Rule 1300.67.3(a)(2)] *(Repeat Deficiency)*

**STATUS: UNCORRECTED**

**Deficiency 12**: **The Plan does not consistently evaluate patterns and trends in quality of care issues and does not monitor provider specific and Plan-wide quality performance issues.** [Rule 1300.70(b)(2)(C)]

**STATUS: UNCORRECTED**

# IV. DISCUSSION OF DEFICIENCIES, FINDINGS, AND CORRECTIVE ACTIONS

## GRIEVANCES and APPEALS

**Deficiency 1:** **The Plan does not have established criteria that address enrollees who have terminal illnesses and who have been denied coverage for treatment, services or supplies that are deemed experimental or investigational.** [Section 1368.1(a)]

**Discussion of Findings:** The Plan defines a "life-threatening condition" as a disease or condition where the likelihood of death is high unless the course of the disease is interrupted; or a disease or condition with potential fatal outcome, where the end point of clinical intervention is survival. The Plan defines "serious debilitating condition" as a disease or condition that causes major irreversible morbidity.

While the Plan has established a policy that provides for external independent review of its coverage denial decisions on the grounds that the treatment is experimental and/or investigational involving enrollees who have "life-threatening" or "serious debilitating" conditions, it has not established a procedure for reviewing and denying services that are deemed experimental or investigational for enrollees with "terminal illness." While there is a similarity in the Plan's definition of "life-threatening condition" and the definition provided by Section 1368.1(a) for terminal illness, "an incurable or irreversible condition that has a high probability of causing death within one year or less", the Plan's current policies (P & P Independent Review for Experimental and Investigational Therapies and Expedited Appeal Request) do not provide for the following in its denial notification to the enrollees with terminal illness:

- A statement setting forth the specific medical and scientific reasons for denying coverage;
- A description of alternative treatment, services, or supplies covered by the plan, if any;
- Copies of the Plan's grievance procedures or complaint form; and
- An opportunity for the enrollee to request a conference.

**Corrective Action 1:** The Plan shall provide evidence to substantiate that it has developed and implemented policies and procedures addressing all requirements specified in Section 1368.1(a).

**Plan's Compliance Effort:** The Plan stated in its response that its "Utilization/Case Management Department revised Terminal Illness, Experimental and Investigational Therapies (Policy and Procedure-UM/CM 1003) to provide a mechanism for members with a terminal illness that have been denied coverage to receive information about alternative therapies and an opportunity to request a conference."

The Plan also stated that "Members who have been denied treatment may file a grievance by telephone, in writing, or by utilizing the UHP website. If the member has filed a grievance with the Plan and is not satisfied with the resolution, he/she may request a grievance hearing as outlined in Member Services Policies and Procedures."

With its response, the Plan submitted as evidence: (1) Policy and Procedure UM/CM 1003, (2) samples of denial letters for Commercial and Medi-Cal members, (3) Member Services Appeals

and Grievances 3.11 Medicare Grievances – Processing Formal Grievances, and (4) Member Services Appeals and Grievances 3.30 Medi-Cal Grievances – Processing.

**Department's Finding Concerning Plan's Compliance Effort:**

The Department found that the Plan had appropriately revised its policies and procedures regarding denial notification to the enrollees with terminal illness.

**STATUS: CORRECTED**

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**Deficiency 2: The Plan does not consistently:**

**A) Acknowledge the receipt of a grievance within five calendar days;**

**B) Provide the enrollee with a written resolution of the grievance within 30 calendar days of receipt of the grievance; and**

**C) Display the Department's telephone number, the California Relay Service's telephone number, and the Department's Internet Website address in 12-point boldface type in its acknowledgment and response letters to grievances. [Rules 1300.68(d)(1) and (3) and 1300.68(b)(2)]**

**Discussion of Findings:** The Department reviewed 20 grievances and 20 appeals files randomly selected from the Plan's grievances and appeals logs covering the period January to April 2003.

**2A**. The review found that all the 20 grievance cases were acknowledged within five calendar days; however, three of the 20 appeals cases were not acknowledged within five calendar days of receipt of the grievance and one case was not acknowledged at all. The acknowledgment letters were sent at various times, ranging from six to nine days following the receipt of the respective grievances.

**2B.** The Department found that two of the 20 appeals cases were not handled in a timely and appropriate manner. In one of the two cases (case # 700008334), the enrollee appealed a benefit denial issued by the medical group. The Plan received and acknowledged the letter of appeal on February 14, 2003. In its acknowledgment letter, the Plan requested that the enrollee submit a copy of the denial letter issued by the medical group. The Plan closed the case on the day the acknowledgment letter was sent to the enrollee. It later reopened the case on February 19, 2003 after receipt of the copy of the denial letter from the enrollee. The Plan eventually resolved the case on March 17, 2003.

In the other case (case # 151936), the enrollee appealed a medical necessity denial issued by the medical group. The Plan received the appeal on November 27, 2002. The Plan requested a copy of the denial letter and closed the case shortly thereafter. On February 12, 2003, the enrollee submitted hospital records to prove the necessity of her emergency treatment. The Plan reopened the case and acknowledged the appeal eight days later on February 20, 2003. The Plan eventually resolved the appeal on March 07, 2003.

Both cases described above were discussed with Plan staff members. The Plan appears to be placing an unnecessary burden and inconvenience on the enrollees to produce documents, such as copies of denial letters, that the Plan already has in its possession or is readily available if needed. The Department is also concerned that the Plan may be inappropriately closing pending cases without providing the enrollee ample time to respond in an effort to meet the 30-day timeframe.

**2C.** In regards to the 20 appeals files reviewed, the Department found that in the Plan's acknowledgment letters, 10 of the 20 did not include the information regarding the Department's grievance review process, the Independent Medical Review (IMR) system, and the Department's toll-free telephone number and website address. In 12 of the 20 resolution letters, the Plan did not include the required information regarding the Department's grievance review process, the Independent Medical Review (IMR) system, and the Department's toll-free telephone number and website address.

In regards to the 20 grievance files reviewed, the Department found that all acknowledgment and resolution letters contained the required information regarding the Department's review process, the Independent Medical Review (IMR) system, and the Department's toll-free telephone number and website address. However, in eight of these 20 cases, the Plan did not display the Department's telephone number, the California Relay Service's telephone number, the Plan's telephone number and the Department's Internet Website address in 12-point boldface type as required.

**Corrective Actions:**

**2A:** The Plan shall submit evidence that it consistently acknowledges grievances and appeals within five calendar days. The Plan shall submit a corrective action plan that will prevent inappropriate or premature closure of pending grievance/appeals cases. The Plan shall submit evidence that it will not place an undue burden on the enrollee to provide information (e.g., denial letters) that the Plan should already have available; and not to close the case or file before all investigation and resolution is complete.

**2B:** The Plan shall submit evidence that it resolves all grievances and appeals within 30 calendar days.

**2C:** The Plan shall submit evidence to substantiate that it consistently displays the Department's telephone number, the California Relay Service's telephone numbers, and the Department's Internet address in its acknowledgments and responses to grievances and displays them in 12-point boldface type as required.

**Plan's Compliance Effort:** The Plan stated in its response that, with regard to Issue A, "Failure to acknowledge the receipt of a grievance within five calendar days, . . . the following actions have been implemented:"

- Training has been conducted to reiterate the importance of sending acknowledgement letters within the allowable timeframes.
- We have conducted a review of non-compliant cases and have identified that most of the delays in timely acknowledgement are the result of delivery delays from other areas of

the company to the Appeals and Grievances Department. We are currently working to enhance internal processes to ensure that all employees are aware they must immediately transition all appeals and grievances to the Appeals and Grievances Department to ensure compliance.

- Although a copy of the denial letter is requested, non-receipt does not delay our review and resolution of the member concerns. Cases are no longer closed as a result of the inability of the Plan to obtain medical records. If there are delays in obtaining these records, assistance is requested from the Provider Network Services (PNS) Department. PNS places a call to the Medical group to assist in expediting delivery of the necessary medical records."

The Plan also stated that "In conjunction with this effort, Policies and Procedures relating to the identification and processing of appeals and grievances have been re-written to provide the Member Services Call Center and Appeals and Grievances staff with more detailed processing instructions. The staff of Member Services Call Center has received training as to how to properly identify and log all types of member concerns and when to transition member issues to the Appeals and Grievances Department for handling. Proper identification will allow the Plan to generate acknowledgement letters in a timely manner."

With regard to Issue B, "Failure to resolve all grievances and appeals within 30 calendar days, the Plan stated that "A tracking mechanism has been implemented, effective November, 2003 to assist the department in identifying and tracking non-compliance in the generation of acknowledgement letters." The tracking log was submitted as evidence of this action.

With regard to Issue C, consistent display of required information, the Plan stated, "Grievance and appeals acknowledgement and resolution letters have been revised to include the required verbiage. In addition, the telephone numbers outlined above have been reflected in bold, as instructed." Sample acknowledgement letters were submitted as evidence of the revisions.

**Department's Finding Concerning Plan's Compliance Effort:**

With regard to Issue A, the Department found that the Plan has initiated training, a tracking log and policy and procedure revision to address the deficiency however, the Plan had not had sufficient time within the 45-day response period to produce evidence of the effectiveness of these corrective actions.

With regard to Issue B, the Department found that the Plan has implemented a tracking process and tracking log; however, the Plan had not had sufficient time within the 45-day response period to produce evidence of the effectiveness of these corrective actions. Additionally, the Department recommends that the log/tracking process be expanded from the tracking of acknowledgment letters (as displayed in the sample sent to the Department) to include all key stages in the handling of grievances and appeals so that tracking of the 30 calendar day timeframe will be facilitated.

With regard to Issue A and B, at the time of the Follow-up Review, the Department will review a sample of cases as well as the Grievance and Appeals Tracking Log to assess compliance with the required timeframes. At that time the Department will evaluate the full implementation and status of the Plan's corrective action to correct this deficiency as requested.

With regard to Issue C, the Department found that the Plan's revised letters incorporate the required information and effectively address the Department's concerns.

**STATUS: ISSUE A: UNCORRECTED**
**ISSUE B: UNCORRECTED**
**ISSUE C: CORRECTED**

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**Deficiency 3: The Plan does not consistently provide enrollees with written responses to grievances that include a clear and concise explanation of the reasons for the Plan's determination. The Plan's resolution letters do not adequately address all enrollees' concerns and expressions of dissatisfaction. [Rule 1300.68(d) (4)]** ***(Repeat Deficiency)***

**Discussion of Findings:** The Department evaluated 10 appeals and 20 grievance files randomly selected from the Plan's appeals and grievances logs during the period covering January to April 2003. In nine of the 10 appeals cases and in eight of the 20 grievance cases, the Plan did not provide the enrollees with written responses that included a clear and concise explanation of the reasons for its determination. The resolution letters were frequently vague and confusing and did not contain an adequate or clear summation of the issue(s). The resolution letters did not fully address the enrollees concerns or properly explain the rationale responsible for the Plan's determination. The following examples are provided for reference:

a. Case # 283908: Resolution letter states: "UHP Healthcare has completed the subsequent review of the incurred expenses previously denied. After a thorough review, the Plan has overturned the aforementioned initial decision to deny payment. As such, the Plan has notified S & S Management of our position in this matter and advised the facility to render payment. Please know that payment will be forwarded under a separate cover."

   Department's comments: While the letter refers to "incurred expenses previously denied," it does not contain the amount of the claim and the type of service that was denied. The enrollee may not know "S & S Management." It is not clear which entity is responsible for paying the enrollee. The letter does not provide clear instructions to the enrollee as to the next step if he/she has not received any payment.

b. Case # 700011268: Resolution letter states: "UHP Healthcare is in receipt of your reconsideration request for services rendered to you by the above referenced provider." (The letter contains 'Re: Memorial Radiology Medical Group Inc, DOS 12/27/02.') Thank you for contacting UHP's Member Services Department regarding the above referenced claim. Please be advised that according to our investigative findings, it was determined that your claim was mistakenly denied by UHP Healthcare. Your claim has been forwarded to El Projecto del Barrio for proper adjudication as their admissions office is responsible for all referred services. As such, your reconsideration case is closed."

   Department's comments: The resolution letter does not clearly indicate the amount of the claim and the type or name of service that is being appealed. It is not clear which entity is responsible for paying the enrollee or the medical group. Forwarding the claim to an entity

(El Projecto del Barrio) with which the enrollee may not be familiar does not resolve the appeal nor does it provide the enrollee with a clear resolution to his/her appeal.

c. Case #21112988: This is a case that involves a denial of a claim, which was later reversed by the billing provider (Pain Management Medical Center). According to the Plan's investigation worksheet, the treating provider at the Pain Management Medical Center later decided to cancel the bill for the service. The enrollee appealed the claim without knowing that the provider had reversed the charges.

The acknowledgment letter states: " UHP Healthcare is in receipt of your request for reconsideration of the denied claims." (The letter does not contain any information regarding the amount of the claim or the name of the service being denied.)

The resolution letter states: "Thank you for contacting UHP regarding the above referenced retro-authorization (possibly referring to 'Re: Pain Management Medical Center DOS 12/20/02'). Please be advised that the Member Services Department has completed a preliminary investigation. According to Pamela Brown at Pain Management Medical Center, your account has 'zero' balance. If you receive any billing statement referencing the above listed date of service, then please forward it to the Member Services Department for handling. As such, further review and investigation of this matter have ceased and your reconsideration case has been closed."

Department's comments: The acknowledgment letter does not clearly state what is being denied. The resolution letter was long and confusing. The Plan could have clearly stated that the provider had reversed the charges and no payment is due from the enrollee.

**Corrective Action 3:** The Plan shall submit a corrective action plan and evidence to substantiate that the Plan:

- Consistently provides enrollees with written responses to grievances that include a clear and concise explanation of the reasons for the Plan's determination. The Plan shall ensure the explanation is understandable by the enrollee (layperson) based on appropriate cultural and linguistic considerations; and

- Consistently addresses all enrollees' concerns and expressions of dissatisfaction.

**Plan's Compliance Effort:** The Plan stated in its response that ". . . resolution letters are written with the goal of addressing the member's concerns in a manner that is thorough and understandable. We have incorporated the Department's recommended verbiage and to address each issue appropriately. In addition, we respond to members in writing, utilizing the language used by the member."

With its response, the Plan submitted as evidence copies of seven member letters and the Plan's resolution responses for each. Four were written in English and three in Spanish.

**Department's Finding Concerning Plan's Compliance Effort:**

The Plan has provided evidence (i.e., a sample of resolution letters written in English and Spanish with clear and concise explanation of the reasons for the Plan' s determination) that they have adequately addressed this deficiency as requested.

**STATUS: CORRECTED**

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**Deficiency 4: The Plan does not consistently specify the provision in the contract, evidence of coverage or member handbook that excludes the service in its benefit denial letters. [Rule 1300.68(d)(5)]**

**Discussion of Findings:** The Department reviewed 20 appeals files randomly selected from the Plan's grievances and appeals logs covering the period January to April 2003. The Department found that one case was denied by the delegated Preferred Provider Network (PPN) on the basis that the service was no longer a covered benefit. The PPN's denial letter did not meet the requirement of Rule 1300.68(d)(5). The denial letter stated: "The service is no longer a covered benefit under UHP Healthcare effective 01-01-2003. Please refer to your member materials for benefit guidelines." The remaining 19 appeals were not benefit-denial related. Although one deficient file may not necessarily establish a trend, this finding becomes significant when pared with a related UM deficiency. For additional information, please refer to UM Deficiency #10 below and the Department's findings regarding the Plan's inadequate UM delegation oversight activities of its contracted PPNs.

**Corrective Action 4:** The Plan shall submit evidence that it consistently specifies the provision in the contract, evidence of coverage or member handbook that excludes the service in its benefit denial letters. The Plan shall submit evidence that delegated providers consistently specify the provision in the contract, evidence of coverage or member handbook that excludes the service in their benefit denial letters.

**Plan's Compliance Effort:** The Plan stated in its response that "In order to ensure that the provisions of the contract, Evidence of Coverage or Member Handbook are appropriately referenced within the denial letters, the Claims Department, in conjunction with Member Services and Utilization Management will review and revise the denial reasons currently in use in the denial letter. A copy of the revised denial letters will be compiled and submitted to DMHC for approval by the end of December, 2003. Training will be provided to all entities that generate these letters to ensure the appropriate letters and denial language is being used."

**Department's Finding Concerning Plan's Compliance Effort:**

The Department found that the Plan had not had sufficient time during the 45-day response period to correct the deficiency. The Plan's expected corrective actions – revision of the denial reasons included in its denial letters and training regarding the use of these letters – will be completed by December 2003. At the time of the Follow-up Review the Department will evaluate the revisions to the denial reasons included in the denial letters and the associated staff training regarding the use of these letters and, the Department will review a sample of denials to monitor implementation. At that time the Department will evaluate the full implementation and status of the Plan's corrective action to correct this deficiency as requested.

**STATUS: UNCORRECTED**

## ACCESS and AVAILABILITY

**Deficiency 5: The Plan does not have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which include, but are not limited to, waiting time and appointments. [Rule 1300.67.2(f)]**

**Discussion of Findings:** The Department found that the Plan has no evidence of established systems or processes in place to monitor, track or evaluate access-related issues. Please refer to the following example that illustrates the lack of the Plan's oversight regarding access-related issues:

The Grievance Summary Report for year 2002 showed a 15% increase in access-related grievances compared to year 2001. The Report noted that the increase might have been a result of internal changes in the Grievance and Appeals Department such as better identification of access-related issues and improvement in categorizing grievances. In response to this finding, the Plan was unable to present evidence that it continued to monitor or track such access-related issues and identify opportunities for improvement. The Plan failed to consider other alternatives or patterns as to the cause and effect relationship that created the increase in access-related grievances from the prior year, such as but not limited to, changes in enrollment demographics or possibly a lack of practitioners (PCP and/or specialty) in some areas of the Plan's provider network. Although the Plan produces monthly, quarterly and yearly grievance reports, the Plan did not provide evidence or substantiate through committee minutes that the Quality Management Committee is reviewing or evaluating aggregate accessibility data as part of its oversight responsibilities.

The Plan has shown no evidence that it systematically identifies enrollees access-related issues. The Plan does not appear to institute interventions when necessary in order to properly evaluate existing or potential access-related issues within its service area.

**Corrective Action 5:** The Plan is required to develop and implement ongoing access-related monitoring and evaluation systems to ensure that adequate health care services are available and accessible to enrollees. The Plan shall submit evidence to substantiate the development and implementation of a system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but not be limited to, waiting time and appointments. The Plan shall submit evidence that the Quality Management Committee reviews and analyzes aggregate accessibility data and reports its findings and corrective action plan, if any, to the Board of Directors (currently, to the Conservator).

**Plan's Compliance Effort:** The Plan stated in its response that the following corrective actions are planned:

1. Effective 01/01/2004 – Access/Availability category will be reflected as a separate QMC agenda item, rather than item within the body of the QM Department report.
2. Additionally Access/Availability will be reported to the newly formed Provider Network Services "Provider Relations Network Oversight Committee" on a regular basis.

3. The current, QM 'Access to Care Monitoring Activities' P & P was in place at time of survey which details (Emergency Care, Urgent Care, Non-urgent care, specialty referral, preventative care, waiting room, after hours care) the monitoring and evaluation system performed by the QM Department on behalf of the organization.
4. Further, the Member Services Department monitors and reports at QMC telephone abandonment rate, and call wait times. This information is tracked and trended.
5. Effective 1/2004, the QM Access to Care Monitoring Activities P & P will also be updated to include statement regarding disciplinary actions/sanctions by the VP/Medical Director for immediate action to a PCP or Medical group should a definitive threat to patient or clinical safety arise due to Access/Availability. Additionally, at the time of the audit, the Access 2002 Survey was underway; however, aggregate results were not available at that time.
6. QM also monitors Access/Availability ongoing by the following means:
   - Membership Survey (reported at QMC);
   - Quarterly medical group reports-Coalition reports;
   - Via the Grievance Process (Access/Availability cases reviewed concurrently for resolution and reported/reviewed at QMC); and
   - Via the Facility Site Review (FSR) process – upon initial audit of PCP, high volume specialist offices and tri-ennially, or upon request as focus audit if problem identified.

With its response, the plan submitted as evidence its Access to Care Monitoring Activities Policy and Procedure, the results of its Access 2002 Survey (which included aggregate data and evidence that the results were reported to the QMC with recommendations), quarterly medical group reports-Coalition reports and its Site Review Survey Tool.

**Department's Finding Concerning Plan's Compliance Effort:**

The Department found that the Plan has developed and begun implementation of proposed corrective actions; however, the Plan has not had sufficient time during the 45-day response period to correct the deficiency. At the time of the Follow-up Review, the Department will review the Plan's full implementation of these actions and evaluate the status of the Plan's corrective action to correct this deficiency as requested. Specifically, the Department will review:

- The Plan's follow-up of the Access 2002 Survey;
- Its adherence to the Access to Care Monitoring Activities Policy and Procedure;
- The analysis, problem identification, corrective actions and follow-up that occur in response to the Member Survey, Quarterly medical group reports-Coalition Report, grievances and facility site review; and
- The frequency and extent of oversight and follow-up by the QMC and the Provider Relations Network Oversight Committee.

**STATUS: UNCORRECTED**

## UTILIZATION MANAGEMENT

**Deficiency 6: The Plan does not show evidence of the Medical Director's responsibility for Utilization Management. [Section 1367.01(c)]**

**Discussion of Findings:** The Medical Director of the Clinical Care Coordination Program oversees the Plan's UM program. The Plan's UM program description is contained in its Healthcare Clinical Care Coordination Program Description - May 2003. This document does not clearly specify the duties and responsibilities of the Medical Director relative to the oversight of the UM program. Interviews with Plan staff were conducted as part of the routine survey. The staff members indicated that the "UM Program Description needs to be updated to reflect the responsibilities of the Medical Director for the oversight of the UM program."

**Corrective Action 6**: The Plan shall submit evidence of a revised Clinical Care Coordination Program Description and a revised Medical Director's position description to delineate the duties and responsibilities of the Medical Director relative to the oversight of the Plan's UM program.

**Plan's Compliance Effort:** The Plan stated in its response that it had revised the Utilization/Case Management Program Plan 2003 as follows to reflect the Medical Director's role within the department and the responsibility and oversight of the Utilization/Case Management Program:

> "All authorizations decisions for benefit coverage and medical necessity are consistent with sound clinical principles and processes and are based on, but not limited to, review of medical records, consultation with the treating practitioners, and review of recognized criteria."
>
> "Additionally, board certified licensed specialists are utilized to assist in making determinations of medical necessity as appropriate. All information to support decision-making is consistently gathered and documented. The Medical Director or his/her Physician designee reviews all denial decisions related to medical necessity and non-covered services. The Medical Director reports directly to the Vice President/Medical Director and is responsible for the clinical oversight within the UM/CM Department."

The Plan also revised the job description for the Medical Director of Utilization/Case Management Department effective June 25, 2003.

With its response, the plan submitted as evidence a copy of Medical Decision Making (Utilization/Case Management Program Plan 200) and the job description for the Medical Director of Utilization/Case Management Department.

**Department's Finding Concerning Plan's Compliance Effort:**

The Department found that the Plan's revisions Utilization/Case Management Program Plan 2003 and the job description for the Medical Director of Utilization/Case Management Department appropriately addressed the Department's concern that the duties and responsibilities of the Medical Director relative to the oversight of the Plan's UM program be thoroughly delineated.

**STATUS: CORRECTED**

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**Deficiency 7: The Plan does not ensure adequate telephone access for providers to request authorization for health care services. [Section 1367.01(i)]**

**Discussion of Findings:** Every Plan shall maintain telephone access for providers to request authorization for health care services. The Plan's Clinical Care Coordination (CCC) Department receives requests for authorization of service. Interviews with Plan staff were conducted as part of the routine survey. When staff members were asked how the CCC Department monitors the providers' telephone access to their department, they stated that they do not currently monitor and analyze telephone access data including the monitoring of call response time and abandonment rate. Also, the Plan does not monitor, either on a periodic basis or through annual delegation audits, provider telephone access at contracted PPNs to which it has delegated UM responsibilities.

**Corrective Action 7:** The Plan shall submit evidence that it has established a written policy and standards for practitioner telephone access to the Plan's Clinical Care Coordination Department for authorization requests and to the delegated PPNs. The Plan shall provide evidence that it has established written procedures for monitoring such telephone access, along with evidence of data collection to measure compliance with these access standards. This data shall be analyzed and appropriate corrective action is taken, if necessary. In addition, the Plan shall provide evidence that, during its annual delegation audits, it has evaluated policies and procedures, data collection and data analysis of telephone access for UM authorization requests at PPNs.

**Plan's Compliance Effort:** The Plan stated in its response that it "has existing policies and procedures in the Utilization/Case Management Department that addresses telephone access for providers requesting authorizations during normal business hours and after hours, including weekends and holidays."

The Plan also reported that it recently implemented a new communication system "that will allow management the capability of collecting and monitoring data such as wait time, length of call, and abandonment rate. Data analyzed from the reports will allow management to trend findings and implement corrective action as needed."

The Plan committed to submitting an analysis of the data collected during the fourth quarter of 2003 to the Department by February 2004.

With its response, the plan submitted as evidence copies of two existing policies and procedures which address telephone access – Initial Determination Process and After Hours Authorization Process.

**Department's Finding Concerning Plan's Compliance Effort:**

The Department found that the Plan had not had sufficient time during the 45-day response period to correct the deficiency. The Plan has implemented a new communication system, which should facilitate effective monitoring. At the time of the Follow-up Review the Department will review the Plan's analysis of their fourth quarter 2003 and subsequent telephone access study data for providers. At the time of the Follow-up Review, the Department will also review the Plan's use of the data to monitor trends and implement corrective actions where these are

indicated and evaluate the full implementation and status of the Plan's corrective action to correct this deficiency as requested.

**STATUS: UNCORRECTED**

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**Deficiency 8: The Plan does not consistently notify the enrollee, in writing or otherwise, when a request for authorization of health care services is delayed or pended when the Plan is not in receipt of all the information reasonably necessary to make a decision. The Plan does not notify the enrollees and providers of the anticipated date on which a decision is likely to be rendered when it becomes aware of the expiration of the timeframe required to process the request for authorization. [Section 1367.01(5)]**

**Discussion of Findings:** The Department reviewed 10 UM denial files. The Department found that the Plan does not notify, in writing or otherwise, the enrollees when a request for authorization is delayed or pended because the Plan is not in receipt of all of the information reasonably necessary to make a decision. During interviews conducted with the UM staff as part of the routine survey, the staff members indicated that the provider is contacted by telephone or facsimile regarding the need for additional information. When a final decision is made regarding the treatment authorization, the Plan also notifies the provider and the enrollee in writing.

**Corrective Action 8:** The Plan shall submit a corrective action plan that provides evidence that it has developed and implemented appropriate policies, procedures or processes to ensure that both providers and enrollees are consistently notified in writing, or otherwise, when an authorization request is delayed or pended for additional information. The notification should specify what additional information is needed, the timeframe for submission and the anticipated date on which a decision is likely to be rendered after receipt of requested information.

**Plan's Compliance Effort:** The Plan stated in its response that its "Utilization/Case Management Department revised the Deferral Treatment Authorization Request (Policy and Procedure UM/CM 2002) to define the process utilized when a request for health services based on medical necessity is deferred."

With its response, the Plan submitted as evidence its revised Policy and Procedure UM/CM 2002, Deferral Treatment Authorization Request and Deferral/Delay of Service Notification Letter

**Department's Finding Concerning Plan's Compliance Effort:**

The Department found that the Plan has made the necessary revisions to its policy and procedure and to its notification letter. The Plan has not had sufficient time within the 45-day response period to monitor and demonstrate the consistent implementation of the policy and procedure. At the time of the Follow-up Review, the Department will review the Plan's performance in providing notifications when authorizations of health care services are delayed or pended and will evaluate the full implementation and status of the Plan's corrective action to correct this deficiency as requested.

**STATUS: UNCORRECTED**

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**Deficiency 9: The Plan does not consistently provide a clear and concise explanation of the reasons for its treatment denial decisions. [Section 1367.01(h)(4)]**

**Discussion of Findings:** The Department reviewed 29 denial files randomly selected from the denial log for the period January to April 2003. Of the 29 denials, the Department found that five did not contain a clear and concise explanation for the Plan's reason/s for denial. The Plan uses denial codes with corresponding technical or clinical language that are vague, not clear or concise and utilize clinical language that is not easily understandable to a layperson.

**Corrective Action 9:** The Plan shall submit evidence that it consistently provides a clear and concise explanation of the reasons for its treatment denial decisions. The Plan shall ensure the explanation is understandable by the enrollee (layperson) based on appropriate cultural and linguistic considerations.

**Plan's Compliance Effort:** The Plan stated in its response that its "Utilization/Case Management Department is currently utilizing the approved version of the HCFA Region IX Pre-Service Denial Reasons and Codes as explanation for treatment denial decisions. The Utilization Management Department has decided to incorporate the Industry-Collaborative Efforts (ICE) Pre-Service Denial Reasons to ensure that the denial explanation is understood by the enrollee (layperson) based on appropriate cultural and linguistic considerations. The Plan will revise policy and procedure to reflect the utilization of the ICE Pre-Service Denial Reasons. Revised policy and procedure will be submitted to the DMHC by December 15, 2003."

With its response, the plan submitted as evidence the ICE Pre-Service Denial Reasons.

**Department's Finding Concerning Plan's Compliance Effort:**

The Department found that the Plan's proposed use of the ICE Pre-Service Denial Reasons would provide acceptable and understandable explanations for treatment denial decisions. The Plan has not had sufficient time during the 45-day response period to complete these revisions. At the time of the Follow-up Review the Department will evaluate the full implementation and status of the Plan's corrective action to correct this deficiency as requested.

**STATUS: UNCORRECTED**

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**Deficiency 10: The Plan does not provide adequate oversight of delegated PPNs to ensure compliance with Plan standards and all applicable statutes and regulations. [Section 1367.01(a)]**

**Discussion of Findings:** The Plan has a complex system of delegation of UM for certain medical care services to more than 50 Preferred Provider Networks (PPNs). For a list of delegated functions, please refer to the Risk Assumption for Health Services matrix found in Section II of this report. There is variation among the PPNs as to which services they perform UM processes for; and oversight of this delegation by the Plan is therefore a complex and resource-intensive

activity. The Plan's policy and procedure of annually auditing each delegated PPN, using the National Independent Practice Association Consortium (NIPAC) audit tool, is designed to measure the compliance or lack of compliance of each delegated PPN with the Plan standards for UM. The Plan provided evidence of having conducted such audits in the past, during which it identified individual PPN deficiencies related to the UM processes and developed corresponding corrective action plans with the respective provider.

While the Plan has established a policy and procedure of annually auditing each delegated PPN to measure their compliance to the Plan's UM standards, it has not performed such audits since 2002. The Plan reports, "this is due in part to the erratic staffing and high overturn rate among Plan officers and staff members in the past 18-24 months."

At the present time, upon interview with UM staff members, they conceded that there are PPNs that may be out of compliance with the Plan's UM standards. The Plan has developed a corrective action plan entitled "Comprehensive Delegated Oversight (CDO) Backlog 2002 Strategic Evaluation and Workplan" to ensure that all audits will be performed timely. The Plan has also developed a schedule of all the delegation audits for 2003, CDO Audit Schedule (May 19, 2003 update). However, despite this proposed audit schedule, the Department noted that some PPNs have yet to be scheduled for auditing.

The Department reviewed four PPN-denial files randomly selected from two PPN denial logs for the period January to April 2003. Of the four PPN denial-files, the Department found two pre-certification denial decisions (one from each of the two PPNs denial logs used in the sample) that took longer than five days to reach a decision after all information was received by the PPN. The delay in the timeliness in rendering a treatment determination (denial) could represent a systemic problem that should be evaluated by the Plan.

Another area for consideration is the Department's finding regarding the Plan's high overturn rate for its denials. Of the 20 appeals case files, eight were initially denied by the PPN and 12 were denied by the Plan. Of the 12 Plan-denials, one claim was incorrectly filed as it belonged to another health plan, and another was referred to the Conservator for administrative review. These two claims were not considered for further review. The Plan overturned seven of the eight the PPN-denials and eight of the 10 of its own denials. A high overturn rate of UM denials could be an indication that there may be some existing or potential problems in the UM process. This high overturn rate issue may warrant further investigation both at the PPN and Plan levels.

**Corrective Action 10:** The Plan shall submit evidence that it has proceeded with its "CDO Backlog 2002 Strategic Evaluation and Workplan" as described above or provide evidence of other mechanisms of monitoring each delegated PPN to ensure they comply with the Plan's established UM standards. The Plan shall also include a progress report regarding the status of this Workplan, the results of the audits, and any newly formulated corrective action plans involving non-compliant PPNs identified by the audits.

The results from the "CDO Backlog 2002 Strategic Evaluation and Workplan" audit should include not only an analysis of the causes for the high percentage of denials but also evaluate the timeliness of the review process and the lack of monitoring of the UM process. In addition, the Plan shall submit evidence that adequate attention and resources have been allocated to the PPN oversight activities so that serious backlog will not occur again in the future. The Plan shall also

incorporate the activities from this evaluation into their annual QA Program, QA Workplan and evaluation.

**Plan's Compliance Effort:** The Plan stated the following in its response:

1. "Status of Medical Group Oversight Audits – The Plan provided a grid which corresponds to the strategic Comprehensive Delegated Oversight Workplan provided at time of audit to resolve the 2002 audits not done, concurrent 2003 annual year audits were also conducted at the same time. The final medical group audit reports have not been finalized as of yet for distribution to the medical groups, however at the conclusion of each audit the Director of Quality Management provides verbal feedback to the key core individuals at the medical group. Final reports to the medical groups for audit time period 2002/2003 will be completed by 12/31/03, with evidence of certified mailing to medical groups.
2. The Plan provided a policy for UM audits and a UM audit tool for the UM component which reflects detail review of medical group network in UM review. The tool will be revised for 2004 by Jan 2004. The Delegated Oversight policy will be revised by Jan 31, 2004. The Comprehensive Delegated Oversight (CDO) staffing current has allocated 1 FTE (in recruitment) CDO Team Leader (RN/LVN), 1 FTE Credentialing Oversight Auditor (on board), 1 FTE Claims Oversight Auditor (on board). This position should be filled by 1st quarter 2004. In the meantime, all but three UM/QM oversight audits have been completed by the Director QM; those medical groups have been scheduled prior to the conclusion of this year. The Plan provided job descriptions for those positions providing oversight function.
3. Report for oversight monitoring and evaluation activities are already reviewed, monitored and reported, and are part of, the Annual QM Evaluation, Program Plan and Workplan.
4. UHP Healthcare's Outcomes Management Department in collaboration with Member Services Department will conduct a retrospective internal audit on medical group denials that have been overturned at the Plan level. Findings of the internal audit will be analyzed to understand the reasons for the high overturn rate. UHP Healthcare will submit findings of the internal audit to the Department of Managed Health Care (DMHC) by the end of the first quarter 2004."

With its response, the Plan submitted as evidence its oversight audit workplan/schedule, its Delegated Utilization Management Oversight Policy and tool, job descriptions for oversight positions and its Annual QM Evaluation, Program Plan and Workplan.

**Department's Finding Concerning Plan's Compliance Effort:**

The Department found that the Plan has initiated and/or planned several corrective actions for addressing this deficiency, including policy /tool revisions, staffing allocations and an internal audit. The Plan has not, however, had sufficient time during the 45-day response period to correct the deficiency. At the time of the Follow-up Review, the Department will review the Plan's workplan of completed and scheduled audits and the results of its internal audit on medical group denials that have been overturned.

Specifically, the Department will review the following:

- Update on current Comprehensive Delegated oversight staffing including hire/assign dates and qualifications of personnel;
- Evidence of certified mailing of all final reports for time period 2002/2003;
- Revised audit tool for 2004 and revised Delegated Oversight policy;
- Copies of final reports (and, if applicable, corrective actions plans) for the following three randomly selected medical groups:
    - Advanced Primary Care IPA
    - El Projecto Del Barrio
    - Stewart Medical Group

The Department will also review a sample of audit results and corrective action plans involving non-compliant PPNs identified by the audits, if any, and will evaluate the full implementation of these actions and the status of the Plan's corrective action to correct this deficiency as requested.

**STATUS: UNCORRECTED**

## QUALITY MANAGEMENT

**Deficiency 11: The Plan does not investigate potential quality issues (PQIs) in a timely manner in order to ensure that the care provided to all enrollees meets professionally recognized standards of practice. [Rule 1300.70(a)(1) and (3) Rule 1300.67.3(a)(2)]** ***(Repeat Deficiency)***

**Discussion of Findings:** The Member Services Department refers grievances to the Quality Management Department if a potential quality of care issue (PQI) is suspected. Quality Management staff members also review the grievance log each week to be certain that no PQIs are missed. The registered nurse (RN) responsible for addressing PQIs reviews the grievance and, when possible, resolves the issue immediately with the provider/member (e.g., if a referral is needed, the RN may contact the appropriate provider to discuss or make arrangement). When indicated, medical records or other documentation is requested in order for the RN and a physician advisor to conduct a more in-depth analysis and determine whether significant quality of care, access issues or patterns of such issues exist. Activity reports are provided to the QMC at each meeting. PQI cases which the physician advisor has identified with level of severity greater than zero are individually reviewed.

During the on-site visit, the Department reviewed 26 PQI files from the fourth quarter 2002 to the first quarter 2003. As noted above, a RN is responsible for the initial monitoring, evaluation and follow-up of PQI cases. The Plan's policy requires a physician advisor to also review all PQI cases. When a PQI case had been identified, the Department found that medical records were promptly requested in order to investigate the cause(s) and seriousness of the PQI issues; however, the Plan was not diligent in following-up to ensure that the records were received in a timely manner. In cases where providers did not respond to the initial request for records, two or more months often passed before a second request was made. There was a delay or absence of RN coordination and lack of follow-up in monitoring the unresolved and open PQI cases. In 10 of the 26 cases, there was a lag of more than 60 days between receipt of the records and the review and write-up by an RN for referral to the physician reviewer. Five of these 10 cases showed a lag of over 90 days from receipt of records until the RN completed the review. In four of these 10 cases, there was a total lag of over 90 days between receipt of records and physician

review; and an additional three cases remained pending physician review for more than 90 days at the time of the Department's review.

In the interviews with key members of the Plan's staff that were conducted as part of the routine survey, the Plan's lead staff explained that difficulties in recruiting qualified RNs (there were several unfilled RN vacancies within the QM Department) had contributed to this PQI case backlog – because there is only one RN currently assigned to this task, her focus has been on resolving immediate issues with providers and working on the most significant cases. In spite of the attempt to prioritize issues, several of these backlogged cases involved medical care issues or delays in treatment which, should potential quality issues be confirmed, may involve significant impact on patients. For example, one hip fracture/surgery case referred by Case Management on 1/24/03 categorized as an "unexpected death" (for which records were received on 3/3/03) had not yet undergone final RN retrospective review or write-up nor had the physician completed his retrospective review. A second death, referred by Member Services in response to a grievance on 2/6/03 had not yet undergone physician review at the time of the Department's June 2003 review. A case involving a seizure/fall in the provider's office, for which records were received on 3/7/03 was not completed by the RN and not reviewed by the physician reviewer until 6/3/03. This case received a Level II severity rating as recommended by the physician reviewer and is awaiting QMC review.

As a result of case review delays at the Quality Management Department, PQIs do not reach the QMC in a timely manner for provider review and, where indicated, the implementation of corrective actions and appropriate measures for preventing future issues. Additionally, information regarding the final results of PQIs is not available for data analysis on patterns and trends.

**Corrective Action 11:** The Plan shall provide evidence that it has addressed the backlog of PQI reviews in order to ensure that it has the capability of addressing the on-going caseload. Corrective actions shall include, but not be limited to:

- Development of a timetable for processing the backlog of PQIs;
- Development/implementation of effective processes for tracking and scheduling tasks for each PQI, including medical record request, record receipt, review (by an RN, physician and, where needed, the QMC) and implementation of appropriate corrective actions; and
- Consistent assignment of an adequate number of qualified staff to address the backlog of PQIs and to efficiently handle the on-going caseload.

**Plan's Compliance Effort:** The Plan listed in its response several corrective actions that have been or will be implemented to address this deficiency:

1. "The Quality Management Director has developed a Grievance Status report Tracking Log, to continue to monitor the status of cases for grievance processing.
2. Backlog grievance processing. An analysis of grievance cases backlogged demonstrates the major backlog is RN Nurse Review of case to MD Reviewer. The VP/Medical Director has directed that for backlog, the health plan physician reviewer will review the

case, summarize the case rather than the RN reviewer at this point. The RN will then prepare to submit those cases to the QMC.

3. Going forward, effective 11-01-2003, the QM Grievance Status Tracking Log for incoming grievance cases will be RN pre-screened and assigned a grievance review severity code:
   - 01: Priority review: RN/MD concurrent review of grievance with Member Services staff resolved on spot (records obtained). Case forwarded to that month's QMC.
   - 02: Concurrent reviewed; no threat to patient or clinical safety. RN reviewed with fax documentation. Case closed, present QMC.
   - 03: Grievance resolved, but QM clinical oversight
   - 04: Low priority: non-clinical patient perception issue (co-pay, floor dirty, rude nurse, etc.)
4. The Grievance QM Severity Code Pre-screen is in practice, however, P & P will be complete draft by 12-15-2003. The VP/Medical Director will review and evaluate any case(s) that ≥ 180 days to assist in the elimination of the Grievance backlog, effective 1/2004.
5. The QM Director prepares and presents a month QM Board of Directors' report to the VP Medical Director, who then presents the findings to the Board. In addition effective 1/2004 the QM Director will present a statistical analysis of grievances to QMC.
6. Staffing: currently there are 2 RN's as Clinical Grievance Coordinators to resolve grievance backlog and resolve concurrent grievances. At this the QM Director will make recommendation to the VP/Med Director regarding the critical operational formula for staffing to sustain timely grievance compliance by developing a ratio of grievance case per month x ratio FTE = staffing needed. This will be completed by 2-15-2004.
7. Additionally, an alternative to streamline grievance filings regarding patient appointments at the Medical group level, access in ambulatory setting will be concurrently referred to UM Case Managers with oversight by QM to ensure timely resolution is met. This pilot process will be initiated 12-1-2003."

With its response, the Plan submitted, as evidence, a sample of the Grievance Status Report and a report of backlogged cases.

**Department's Finding Concerning Plan's Compliance Effort:**

The Department found that the Plan has not had sufficient time during the 45-day response period to correct the deficiency. Several corrective actions have been or will be implemented, including a Grievance Status Tracking Log, Severity Code Pre-screen system, physician reviewer summarizing of backlog cases and streamlining of grievance filings regarding patient appointments. At the time of the Follow-up Review, the Department will evaluate the full implementation and status of the Plan's corrective actions to correct this deficiency as requested. The Department will also review the Grievance and Appeals Tracking Log and a sample of cases to assess the timeliness of the Plan's investigation of potential quality issues.

**STATUS: UNCORRECTED**

**Deficiency 12: The Plan does not consistently evaluate patterns and trends in quality of care issues and does not monitor provider-specific and Plan-wide quality performance issues. [Rule 1300.70(b)(2)(C)]**

**Discussion of Findings:** The Plan reviews and conducts follow-up activities on provider-specific issues discovered during provider audits or review of grievances. The Plan has also recently instituted the collection of additional quality of care related data from providers and members through surveys and reports. The Plan has not however, developed a formal reporting mechanism and analysis system sufficient to evaluate and analyze patterns and trends related to quality issues. The Plan does not assess or evaluate quality of care data sources such as grievances, audit results, encounter data and provider surveys, in order to consistently investigate patterns and trends in quality of care issues.

The Plan has not developed quality reports, which would serve as effective analysis tools (e.g., display the integrated data, display Plan-wide performance rates, compare/rank provider rates, identify outliers, profile individual providers on a variety of measures, identify performance issues which are common to a number of providers) to monitor and evaluate provider-specific and Plan-wide quality performance issues.

The Plan did not provide evidence that it consistently analyzes and provides follow-up on the data that it currently has available in order to identify and address quality issues (e.g., committee minutes showed insufficient follow-up on decreases in satisfaction survey rates and on decreases in the number of PQI referrals from the CCC). In addition, due to lags in PQI case review (see Deficiency #11), the Plan did not incorporate timely data on PQIs into its monitoring of quality related issues and quality assessment of individual providers. The Plan's analysis also did not show consistent use of comparative data (e.g., national/regional norms for satisfaction survey items) to: (a) identify potential quality concerns, and (b) identify benchmarks for use in setting challenging yet reasonable performance standards and goals.

The Plan has established annual performance improvement goals (many of which were set at an increase of ten percentage points over prior experience) which appeared to be set arbitrarily rather than through thorough analysis of: (a) past Plan performance, (b) prior annual increases/decreases in performance, (c) national/regional benchmarks identifying mean rates and rates at "high performing" plans, and (d) analysis of the reasonable impact to be expected through potential interventions.

**Corrective Action 12:** The Plan will submit a corrective action plan that consistently evaluates patterns and trends in quality of care issues that includes the monitoring of provider-specific and Plan-wide quality performance issues. The CAP shall also include, but not be limited to, evidence that the Plan has incorporated the following into the Plan's QA Program, Workplan and Annual Evaluation:

- Development of a mechanism or process that evaluates quality of care issues or reports to assess patterns/trends/issues.

- Ensure consistent follow-up of quality of care issues at the QMC and Board (currently, Conservator) level;

- Establish performance goals and monitor performance and identify issues for potential quality improvement projects; and

- Track and trend results of interventions.

**Plan's Compliance Effort:** The Plan stated in its response that the following corrective actions have been or will be implemented to address this deficiency:

1. "The VP/Medical Director re-instituted reporting of QM Report to the Board of Directors, as of June 2003.
2. The current QM Grievance database will be re-engineered for new and additional reports, which will assist in the trending, assessing and reporting patterns.
3. The Plan's current QA Program, Workplan and Annual Evaluation reflect revised documentation regarding the grievance process, trending analysis.
4. Future plans are in process for the development of additional mechanisms and processes to consistently evaluate patterns and trends in quality of care issues, which will include the monitoring of provider-specific and Plan wide quality performance issues – Report Card, with the assistance of Healthcare Informatics Sr. Analysis. Implementation of this process is targeted to occur 1st quarter 2004. A workplan for this process will be drafted by 12/20/2003."

With its response, the plan submitted as evidence its QM/QI Program Plan 2002-2003.

**Department's Finding Concerning Plan's Compliance Effort:**

The Department found that the Plan has not had sufficient time during the 45-day response period to correct the deficiency. Several corrective actions have been implemented or are in the planning stages. At the time of the Follow-up Review, the Department will review the Plan's full implementation of these actions and evaluate the status of the Plan's corrective action to correct this deficiency as requested. The Department will also review the Plan's performance after implementing its QA Program and Workplan, its monitoring of provider-specific and Plan-wide quality performance, its analysis of the additional reports and Report Card which are used to monitor performance, and the QMC and Board minutes regarding follow-up of quality of care issues.

**STATUS: UNCORRECTED**

# V. OUTSTANDING DEFICIENCIES FROM THE FOLLOW-UP REVIEW

This section represents the current status of those Deficiencies found at the last routine medical survey conducted in June 2000 with Final Report issued to public file on February 14, 2001, that remained uncorrected at the time of the Follow-up Review. Those uncorrected Deficiencies were addressed in the Follow-up Report, which was issued to the public on September 25, 2002.

As noted in the introduction section, in the fall of 2001, the Department appointed a Conservator to oversee the Knox-Keene license operations of the Plan. The Conservator made adjustments in the management organizational structure of the Plan that included, in part, the disbandment of the Governing Body (Board of Directors or BOD). Therefore, the Conservator currently performs oversight activities that would typically be the responsibility of a Governing Body or Board of Directors.

As a result of the organizational changes made by the Conservator, some Deficiencies were unable to be corrected at the time of the previous Follow-up Report (to Public) of September 25, 2002 as they related to issues and references to facts that are no longer valid (i.e., duties and oversight responsibilities ordinarily the responsibility of a BOD). At the time of the issuance of the Follow-up Report and due to these organizational changes, the Department found some issues associated with a Deficiency that was no longer valid. Such invalid issues were labeled **'Deferred'**.

Though the Department deferred some areas of the Deficiencies that were no longer valid, the Plan was expected to become fully compliant with the remaining core issues identified in the respective Deficiency and be able to provide evidence of full compliance by the time of this routine survey.

## GRIEVANCE AND APPEALS

**Deficiency:** **The Plan's Member Services Department does not consistently identify and classify informal complaint calls as grievances when enrollees request a change of primary care providers based on concerns with access, delays in referrals, or quality of care. [Sections 1368(a)(1) and 1368.02(b), Rule 1300.68(b)(7)]**

**Outstanding Issue(s) at the Time of the Follow-up Report:**

At the time of the Follow-Up Report, the Plan's Member Services Department did not consistently identify and classify informal complaint calls as grievances when enrollees requested a change of primary care providers based on concerns with access, delays in referrals, or quality of care issues. Had the Plan properly categorized the complaint call as a grievance at the time of the call, the concern could have been addressed by the Plan in a timelier manner. The Plan should have accepted and acted upon such concerns as grievances when received by telephone initially, as they did when the grievance was made in writing.

**Department's Finding Concerning the Plan's Compliance Effort:**

The Department's June 2003 Routine Medical Survey found that all enrollee requests for a change of primary care provider, due to concerns with access, delays in referrals, or quality of care, are coded as access or quality of care grievances, as appropriate, and entered into the Plan's data system.

Further, with the Plan's implementation of Section1300.68 (d)(8) since 2003, all grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are logged in to it Quick Grievance. The Plan's Quick Grievance Log for the period January thru April 2003 recorded a total of 502 such grievance calls.

**STATUS: CORRECTED**

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**Deficiency: The Plan's grievance review process did not demonstrate that resolution letters address all enrollees' concerns and expressions of dissatisfaction. [Section 1368.01(a) and 1368.02(b), Rule 1300.68(b)(7)]**

**Outstanding Issue(s) at the Time of the Follow-up Report:**

The Department's review of several grievance file resolution letters for 2001 and 2002 found that efforts had been made by the Plan to issue adequate written notification to enrollees regarding the Plan's resolution and the letters also included the standard language at the end describing the additional option of contacting the Department if the enrollee is not satisfied. However, in at least two (2) files reviewed**,** the resolution letters were issued past the thirty-day time requirements.

At the time of the Follow-up Report, the Plan stated that it was in the process of working with the Office of Legal Affairs, the Medical Director, and the Director of QM to coordinate complete responses to enrollees regarding medical care and that the Member Services Department revised its policies and procedures to incorporate written responses from the QM staff on medical issues into the Plan's resolution letters. The Plan stated that the QM staff would advise the Member Services Department of the appropriate language addressing enrollees' medical issues that was to be included in the written notification to enrollees and that the Member Services Department would not limit enrollee notification to form letters.

**Department's Finding Concerning Plan's Compliance Effort:**

The Plan has provided evidence (i.e., a sample of resolution letters written in English and Spanish with clear and concise explanation of the reasons for the Plan' s determination) that they have adequately addressed this deficiency as requested.

**STATUS: CORRECTED**

## ACCESS AND AVAILABILITY

**Deficiency: The Plan could not demonstrate that the Plan conducted an accessibility monitoring system meeting Knox-Keene Act requirements. (Repeat Deficiency). [Section 1367(e)(1), Rule 1300.67.2(e) and (f) and 1300.70(a)(3) and (b)(2)(G)(5)]**

**Outstanding Issue(s) at the Time of the Follow-up Report:**

At the time of the Follow-up Report, the Plan failed to adequately respond to the CAP by providing evidence to substantiate that the Plan's access monitoring system met Knox-Keene requirements. The Plan's response that it conducted access monitoring as part of its "at-least-once-every-two-year Integrated Provider and Facility Review process" was inadequate to satisfy the CAP requested by the Department. Additionally, the Plan did not provide evidence regarding:

- Appointment wait times;
- Frequency of access monitoring;
- Information on the Plan's methodology for the regular validation of provider-self-reported access data; or
- Evidence of the timely follow-up with providers that were found to have access related issues.

The Plan had established a methodology to identify and monitor high volume specialty providers; however, the Plan's methodology referenced the selection of the top 10 specialty providers by volume rather that the top 10 physician specialty types by volume as requested.

**Department's Finding Concerning the Plan's Compliance Effort:**

The Plan provided evidence that it has various independent methodologies in place to monitor access and availability including, but not limited to, Geo Access Mapping, Grievance Reports, Quarterly Provider Self-Reporting, and Re-credentialing Audit; however, it remains unclear as to how the Plan effectively utilizes this information to track, trend (on a rolling basis), or correct access and availability related issues by individual PCP, SCP, IPA/Group and/or facility.

The Department found:

- The Plan does not appear to have collated grievance reports by provider and/or facility including hospitals and ancillary care service sites;

- The Plan states that it uses the findings of the re-credentialing audits to validate the quarterly self-reported access information; however, the Plan did not provide documentation of this process or findings to substantiate that the process actually occurs;

- The Plan did not substantiate that it conducts an aggregate review of the collated data from the various data sources to monitor access and availability compliance; and

- The Plan did not provide evidence that the Quality Management Committee or the Board of Directors provides oversight of the access and availability process and analyses or conducts a review of access and availability data at least annually.

The Plan still does not appear to have the appropriate processes in place to identify chronic or systemic access and availability issues within its internal and external care delivery system. As a result, it is still not evident that the Plan evaluates access and availability compliance,

implements and monitors corrective action plans with its providers or facilities or identifies opportunities for improvement.

**STATUS: UNCORRECTED**

This is a Repeat Deficiency. Please refer to Deficiency 5 of this Report regarding the CAP required to correct this deficiency.

## QUALITY MANAGEMENT

**Deficiency:** **The Plan's Quality Management Program did not consistently ensure that the Plan's identification of quality of care problems through its review of individual patient cases, including quality-of-care related grievances, resulted in the implementation of corrective action plans to effectively address identified problems. [Section 1370, Rule 1300.70(a)(1) and (b)(1)(A) and (B)]**

**Outstanding Issue(s) at the Time of the Follow-up Report:**

The Department found that the Plan's QM Program did not consistently ensure that the identification of quality problems through the review of quality-related grievances (quality concern grievances) resulted in the implementation of corrective action plans to effectively address identified problems. The Department's review of five files found that in three cases, the Plan failed to identify and act upon the Potential Quality Concern (PQC) issues raised in a timely manner.

During interviews conducted with Plan staff, they stated that efforts had been initiated as part of the 2002 Quality Management Plan to shore up the communication and intervention process between the Quality Management Department (which is under one Director) with the Member Services Department (which is under another Director) in order to have closer clinical review of all grievances received.

At the time of the Follow-Up Report, the Department deferred a component of this Deficiency, which relates to the absence of a formal reporting process to the Governing Body due to the disbandment of the BOD by the Conservator. Although the Department acknowledged the changes the Plan had experienced both from an operational and management level, the Department required that immediate attention be placed on the related processes involving the identification of PQC issues coming in via the telephone or in written complaints and/or grievances. The Department required that there be a seamless transfer of grievance information between the two organizational areas (Quality Management and Member Services).

**Department's Finding Concerning the Plan's Compliance Effort:**

The Plan has taken steps to address the corrective actions mandated in the previous Preliminary and Final Reports, including improving communication between the Quality Management Department and the Member Services Department; however delays and failures to address Potential Quality Issues (PQIs) continue. As detailed more thoroughly under Deficiency #11 in Section IV, 26 PQIs were reviewed during the Department's on-site visit. The Department found that the Plan was not diligent in following-up to ensure that medical records were received for

review. Moreover, when records did arrive, the Plan did not complete the review/resolution in a timely manner. In 10 of the 26 cases, there was a lag of more than 60 days between receipt of records and review/write-up by an RN for referral to the physician reviewer. In four of these 10 cases, there was a total lag of over 90 days between receipt of records and physician review; an additional three cases remained pending physician review more than 90 days at the time of the Department's review. As a result of these delays at the Quality Management Department level, PQIs did not reach the QMC for definitive identification of quality issues in a timely manner. This, in turn, precluded timely implementation of corrective actions and initiation of appropriate measures for preventing future issues.

**STATUS: UNCORRECTED**

This is a Repeat Deficiency. Please refer to Deficiency 11 of this Report regarding the CAP required to correct this deficiency.

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**Deficiency:** **The Plan Committee that the Plan had designated as having ultimate responsibility for ensuring the effective implementation of the Plan's QM Program, the Executive QM Committee, did not meet, and report to the Board, on a quarterly basis in accordance with the Plan's QM Program description. [Section 1370, Rule 1300.70(b)(1)(A) and (B) and 1300.70(b)(2)(C)]**

**Outstanding Issue(s) at the Time of the Follow-up Report:**

The Department's review found that with the reporting structure changes as a result of the Conservatorship, the Executive QM Committee had been disbanded and in its place had been a re-engineering of the QM Committee which was acting as the overall reporting line to the Plan CEO on issues related to QC. The QM Committee was designated with the authority for the Plan's Quality Management program. As evidence, the Plan supplied committee meeting minutes that provided a list of the QM activities of the Plan. The following was reported in the Quality Management Committee minutes, dated April 25, 2002, "…Director QM reported that for the past year and a half the QMC has not forwarded a report to the BOD during the conservator transition, however the Credentials Sub-committee has submitted its report for review and approval. Starting June 2002 a BOD report would be submitted for review and approval inclusive of Credentialing Sub-committee recommendations." As an action item it is stated "BOD report inclusive of Credentialing Sub-committee will be re-implemented June 2002."

At the time of the Follow-up Report, the Department deferred a component of this Deficiency, which relates to the absence of a formal reporting process to the Governing Body due to the disbandment of the BOD by the Conservator. The Department stated that it would review the processes for communication upward of findings and actions taken as a result of the QA Program to a newly re-created Board as defined in Rule 1300.70(b)(2)(C) at the time of the next routine medical survey. The Department deferred this deficiency with the QMC to be used as a substitute for the Board in the interim.

**Department's Finding Concerning the Plan's Compliance Effort:**

At the time of the previous Final Report, the Plan expected to have in place a newly re-created Board, which would have ultimate responsibility for implementation of the Plan's QM program. At the time of the current on-site visit, the Conservator and the Plan were still in the process of re-establishing the Board. The Plan continued to use the QMC as the primary oversight body for QM Department activities with the Conservator and Plan CEO receiving monthly reports for oversight. Those reports were not "sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components which the QA program has identified as presenting significant or chronic quality of care issues." This left the bulk of monitoring in the hands of the QMC. Review of the QMC minutes provided evidence that the QMC has been meeting on a regular basis and has been performing monitoring of the QM program.

**STATUS: DEFERRED (regarding the Board reporting structure)**
**CORRECTED (regarding effective substitute at this point in time)**

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**Deficiency: The Department found that the Plan had not incorporated the evaluation of aggregate complaint information into its QM Program and had not provided for the Board's receipt and review of tabulated complaint information, at least quarterly, in relation to policy and procedure review. [Section 1370, Rule 1300.68(b)(3) and 1300.70(b)(1)(A) and (B)]**

**Outstanding Issue(s) at the Time of the Follow-up Report:**

At the time of the Follow-up Report, the Department deferred a component of this Deficiency, which relates to the absence of a formal reporting process to the Governing Body due to the disbandment of the BOD by the Conservator. As with the previous deficiency, the Department found that the organizational structure with the Conservator made it difficult to determine the Plan's effectiveness in correcting the deficiency as requested. Among the items that were taken into consideration was the fact the QM Director that was referenced in the Final Report, as being responsible for the implementation of the new processes, is no longer with the Plan. The new QM Director assumed the duties in February 2002. In discussion with the current QM Director, the Department found that there is an entire re-engineering of the Member Services and QM Departments to address the issues that were stated in the deficiency. Again, since there was not a Plan Board currently in existence, no Board minutes were available to review whether they were routinely reviewing tabulated grievance data.

However, the Department did note that, at the Quality Management Committee for April 25, 2002, there was discussion of aggregate level numbers related to "QM related Member Services Complaints/Grievance" along with PQC follow-up Action Log and additional PQC issues." In addition, the Department's review of the 2001 and 2002 QM Workplan provided evidence of several on-going action items involving the monitoring and analysis of quality of care concerns at the aggregate level. The Department deferred this deficiency with the QMC to be used as a substitute for the Board in the interim.

**Department's Finding Concerning the Plan's Compliance Effort:**

Please refer to the discussion for the above Deficiency for additional information. It should also be noted that aggregate grievance and complaint data has been reviewed by the QMC and that this information has been a part of the information reported to the Conservator/CEO.

**STATUS: DEFERRED (regarding the Board reporting structure)**
**CORRECTED (regarding effective substitute at this point in time)**

# A P P E N D I X A

## List of Surveyors

The Survey Team consisted of the following persons:

| DEPARTMENT OF MANAGED HEALTH CARE REPRESENTATIVES | |
|---|---|
| Ed Foulk, RN, MBA, Ed.D. | Staff Health Plan Analyst, DMHC |

| MANAGED HEALTHCARE UNLIMITED, INC. REPRESENTATIVES: | |
|---|---|
| Rose Leidl, RN, BSN | Project Manager, Grievance & Appeals Surveyor |
| Bernice Young | Program Director, Grievance & Appeals Surveyor |
| Patricia Allen, MA, C.H.C.A. | Quality Management Surveyor |
| Mark Leveaux, MD | Utilization Management Surveyor |
| Linda Occelli | Access and Availability of Services Surveyor |

# A P P E N D I X B

## List of Staff Interviewed

The following are the key Plan officers and staff who were interviewed during the on-site survey at the Plan's administrative office on June 9-12, 2003.

| WATTS HEALTH FOUNDATION | |
|---|---|
| | |
| Cheryl Campbell | Manager, Grievances and Appeals |
| Darryl Leong, MD, MPH | Medical Director-QM and Healthcare Informatics |
| Elizabeth Futch, RN | Director Quality Management |
| Glenn Chavez, PharmD, | Director of Pharmacy for UHP (Employee of MedImpact) |
| Henry Baily, MD | Medical Director Clinical Care Coordination |
| Joseph W. Spooner, MD, MBA | Vice President and Chief Medical Officer |
| Melissa Frederick, BSN, RN | Director, Clinical Care Coordinator |
| Norma Shishido | Associate Director, Member Services |
| Ron Bolding | VP, Business Operations |
| Troy Darnell | Senior Analyst, Network Management |

# A P P E N D I X C

## List of Staff Interviewed at Plan Medical Groups

The following key PPG officers and staff were interviewed during the on-site survey of each PPG listed below on June 11, 2003.

| AMM/ADVANCED MEDICAL MANAGEMENT FOR: OMNICARE MEDICAL GROUP | |
|---|---|
| | |
| Eric C. Hayden | Administrator |
| Judy Johnson, LVN | Medical Management |
| Linda McCormick | Case Management |

| WATTS HEALTH CENTER | |
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| Roderick Seamster, MD | Medical Director |
| Jose Juarez | Associate Director Customer Service |
| Florence Kellogg, RN | Interim Nursing Director Case Management/Utilization |
| Chantel Carter | Customer Service Representative |
| Oliver Brooks, MD | Chief of Pediatrics |

| LA VIDA MEDICAL GROUP | |
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| Jim R. Brown, MBA, MPH | Chief Operations Director |
| Debbie Pitts, RN | Chief Nursing Officer |
| Michael A. Ghani | Director Clinic Operations for Specialists |

# A P P E N D I X D

## List of Applicable Statutes and Regulations

The following are the specific citations used in this Routine Medical Survey Report as the basis for the deficiencies.

## GRIEVANCES and APPEALS

**Deficiency 1: The Plan has not established criteria that addresses enrollees with terminal illness who have been denied coverage for services that are deemed experimental or investigational. [Section 1368.1(a)]**

**Citation:**
**Section 1368.1(a)**
A plan that denies coverage to an enrollee with a terminal illness, which for the purposes of this section refers to an incurable or irreversible condition that has a high probability of causing death within one year or less, for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider, shall provide to the enrollee within five business days all of the following information:
(1) A statement setting forth the specific medical and scientific reasons for denying coverage.
(2) A description of alternative treatment, services, or supplies covered by the plan, if any. Compliance with this subdivision by a plan shall not be construed to mean that the plan is engaging in the unlawful practice of medicine.
(3) Copies of the plan's grievance procedures or complaint form, or both. The complaint form shall provide an opportunity for the enrollee to request a conference as part of the plan's grievance system provided under Section 1368.

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**Deficiency 2: The Plan does not consistently:**

**A. Acknowledge the receipt of a grievance within five calendar days;**

**B. Provide the enrollee with a written resolution of the grievance within 30 calendar days of receipt of the grievance; and**

**C. Display the Department's telephone number, the California Relay Service's telephone number, and the Department's Internet address in 12-point boldface type in its acknowledgment and response letters to grievances. [Rules 1300.68(d)(1) and (3) and 1300.68(b)(2)]**

**Citation:**
**Rule 1300.68(d)(1)**
A grievance system shall provide for a written acknowledgment within five (5) calendar days of receipt, except as noted in subsection (d)(8). The acknowledgment will advise the complainant that the grievance has been received, the date of receipt, and provide the name of the plan

representative, telephone number and address of the plan representative who may be contacted about the grievance.

**Rule 1300.68(d)(3)**
The plan's resolution, containing a written response to the grievance shall be sent to the complainant within thirty (30) calendar days of receipt, except as noted in subsection (d)(8). The written response shall contain a clear and concise explanation of the plan's decision. Nothing in this regulation requires a plan to disclose information to the grievant that is otherwise confidential or privileged by law.

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**Deficiency 3: The Plan does not consistently provide enrollees with written responses to grievances that include a clear and concise explanation of the reasons for the Plan's response. The Plan's resolution letters do not adequately address all enrollees' concerns and expressions of dissatisfaction. [Rule 1300.68(d) (4)]** ***(Repeat Deficiency)***

**Citation:**
**Rule 1300.68(d)(4)**
For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the plan shall include in its written response, the reasons for its determination. The response shall clearly state the criteria, clinical guidelines or medical policies used in reaching the determination. The plan's response shall also advise the enrollee that the determination may be considered by the Department's Independent Medical Review system. The response shall include an application for Independent Medical Review and instructions, including the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814.

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**Deficiency 4: The Plan does not consistently specify the provision in the contract, evidence of coverage or member handbook that excludes the service in its benefit denial letters. [Rule 1300.68(d)(5)]**

**Rule 1300.68(d)(5)**
Plan responses to grievances involving a determination that the requested service is not a covered benefit shall specify the provision in the contract, evidence of coverage or member handbook that excludes the service. The response shall either identify the document and page where the provision is found, direct the grievant to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific health care service or benefit requested by the enrollee. In addition to the notice set forth at Section 1368.02(b) of the Act, the response shall also include a notice that if the enrollee believes the decision was denied on the grounds that it was not medically necessary, the Department should be contacted to determine whether the decision is eligible for an Independent Medical Review.

## ACCESS and AVAILABILITY

**Deficiency 5: The Plan does not have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which include, but is not limited to, waiting time and appointments. [Rule 1300.67.2(f)]** ***(Repeat Deficiency)***

**Rule 1300.67.2(f)**
Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments.

## UTILIZATION MANAGEMENT

**Deficiency 6: The Plan does not show evidence of the Medical Director's responsibility for Utilization Management. [Section 1367.01(c)]**

**Citation:**
**Section 1367.01(c)**
Every health care service plan subject to Section 1367.01, shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued to pursuant Section 2050 of the Business and Professional Code or pursuant to Osteopathic Act, or if the plan is a specialized health care services plan, a clinical director with a California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section.

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**Deficiency 7: The Plan does not ensure adequate telephone access for providers to request authorization for health care services. [Section 1367.01(i)]**

**Citation:**
**Section 1367.01(i)**
Every health care service plan subject to this section shall maintain telephone access for providers to request authorization for health care services.

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**Deficiency 8: The Plan does not consistently notify the enrollees and providers, written or otherwise, when a request for authorization is delayed or pended when the Plan is not in receipt of all the information reasonably necessary to make a decision. The Plan does not notify the enrollees and providers of the anticipated date on which a decision is likely to be rendered when it**

**becomes aware of the expiration of the timeframe required to process the request for authorization. [Section 1367.01(5)]**

**Citation:**
**Section 1367.01(5)**
If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary…the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever comes first, ... notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify or deny the request for authorization with the time frames specified in paragraph (1) or (2), whichever applies.

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**Deficiency 9: The Plan does not consistently provide a clear and concise explanation of the reasons for treatment denial decisions. [Section 1367.01(h)(4)]**

**Citation:**
**Section 1367.01(h)(4)**
Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively or concurrent with the provision of health care service to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan‘s decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding clinical necessity.

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**Deficiency 10: The Plan does not provide adequate oversight of delegated PPNs to ensure compliance with Plan standards and all applicable statutes and regulations. [Section 1367.01(a)]**

**Citation:**
**Section 1367.01(a)**
A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively or concurrently with, the provision of health care services to enrollees, or that delegated these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

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**Deficiency 11: The Plan does not investigate potential quality issues (PQIs) in a timely manner in order to ensure that the care provided to all enrollees meets professionally recognized standards of practice. [Rule 1300.70(a)(1); Rule 1300.67.3(a)(2); Rule 1300.70(b)(2)(C)]** ***(Repeat Deficiency)***

**Citation:**
**Rule 1300.70(a)(1)**
The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

**Rule 1300.67.3(a)(2)**
The organization of each plan shall provide the capability to furnish in a reasonable and efficient manner the health care services for which subscribers and enrollees have contracted. Such organization shall include…2) staffing in medical and other health services, and in fiscal and administrative services sufficient to result in the effective conduct of the plan's business.

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**Deficiency 12: The Plan does not consistently evaluate patterns and trends in quality of care issues and does not monitor provider specific and Plan-wide quality performance issues. [Rule 1300.70(b)(2)(C)]**

**Citation:**
**Rule 1300.70(b)(2)(C)**
… The plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. Reports to the plan's governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components, which the QA program has identified as presenting significant or chronic quality of care issues.

# A P P E N D I X E

## List of Acronyms

| Acronyms | Definition |
|---|---|
| AIM | Access for Infants & Mothers |
| BOD | Board of Directors or Governing Body |
| CAP | Corrective Action Plan |
| CCC | Clinical Care Coordination Department |
| CDO | Comprehensive Delegated Oversight |
| CMS | Center for Medicare and Medicaid Services |
| DBA | Doing Business As |
| DOS | Date of Service |
| FEHB | Federal Employees Health Benefits Program |
| HMO | Health Maintenance Organization |
| IPA | Independent Practice Association |
| MG | Medical Group |
| PCP | Primary Care Physician |
| PPN | Preferred Provider Network (also may mean IPA/MG) |
| PQI | Potential Quality Issue |
| QM | Quality Management |
| QMC | Quality Management Committee |
| SCP | Specialty Care Physician |
| UM | Utilization Management |